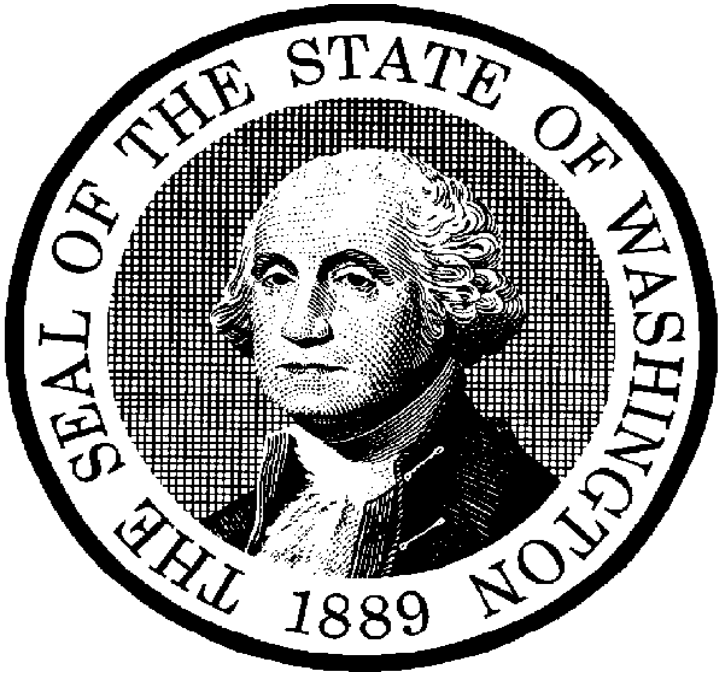
Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration



Federally-Qualified Health Centers (FQHC)

Policies and Billing Instructions

August 2000

About this publication

This publication supersedes all previous Federally-Qualified Health Center Billing Instructions.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
August 2000

Current Procedure Terminology CPT

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Section F: Cost Reporting Requirements

Section G: Diabetes Education Program

Section H: General Billing

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (WAC 388-502-0020(2)).

Applying for a provider

Call the toll-free line:
(800) 562-6188, Select Option 1

or call one of the following numbers:

(360) 725-1033
(360) 725-1026
(360) 725-1032

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9247
Olympia WA 98507-9247

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

or write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Where do I call if I have questions regarding…

Policy, payments, denials, or general questions regarding claims processing, Healthy Options?

Provider Relations Unit
(800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic billing?

Write/call:
Electronic Billing Unit
PO Box 45511
Olympia, WA 98504-5511
(360) 725-1267

Definitions

This section defines terms and acronyms used in this booklet.

Accept Assignment – A process through which a medical provider agrees to accept Medicare payment for a given service or equipment as payment in full, except for specific deductible and coinsurance amounts for which the client is responsible.

Applicant – A person who has applied for Medical Assistance benefits.

Authorization - Official approval for department action.

Authorization Number - A nine-digit number assigned by MAA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Client - An applicant for, or recipient of, DSHS medical care programs. (WAC 388-500-0005)

Clinical Social Worker - The term clinical social worker (as defined by 42 USC, 1395x(hh), Sec. 1861(hh)(1)) means an individual who:

A. Possesses a master's or doctor's degree in social work;
B. After obtaining such a degree, has performed at least two years of supervised clinical social work; and
   (i) Is licensed or certified as a clinical social worker by the state in which the services are performed, or
   (ii) In the case of an individual in a state which does not provide for licensure or certification --
      I. Has completed at least 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting (as determined by the Secretary of Health and Human Services), and
      II. Meets such other criteria as the Secretary of Health and Human Services establishes.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. (WAC 388-500-0005)

Core Provider Agreement - A basic contract that MAA holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in MAA programs.

Department - The state Department of Social and Health Services [DSHS]. (WAC 388-500-0005)

Diabetic Education – A program that provides education or nutrition, exercise, prevention of acute and chronic complication, and monitoring and management.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) - Also known as the "healthy kids" program, means a program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid or the children's health program. (WAC 388-500-0005)

Encounter - An encounter is a face-to-face contact between a client and a provider of health care services who exercises independent judgement in the provision of health services to the individual client. (For a health service to be defined as an encounter, it must meet the specific encounter criteria and provision of the health service must be recorded in the client's record.)

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Federally Qualified Health Center (FQHC) - A facility that is: 1) receiving grants under section 330 of the Public Health Services Act; OR 2) receiving such grants based on the recommendation of the Health Resources and Services Administration within the Public Health Service, as determined by the Secretary to meet the requirements for receiving such a grant, OR 3) a tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL93-638). Only Health Care Financing Administration-designated FQHCs will be allowed to participate in the program.

Health Care Financing Administration (HCFA) - A federal agency within the U.S. Department of Health and Human Services that oversees Medicaid and Medicare policies and procedures. HCFA also defines and assesses the quality of and the standards for health care delivery.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

Maternity Case Management (MCM) - Services which will assist medical assistance eligible pregnant/parenting women and their families in gaining access to needed medical, social, educational, and other services (Social Security Act [SSA] 1915[g]). Maternity case management includes use of community linkages; a comprehensive, on-going identification of client/family needs including medical, social, and educational services; the development and implementation of a

detailed service plan; advocacy to ensure achievement of service plan goals in an accountable manner; and authorization of First Steps Child Care.

Maternity Support Services (MSS) - Preventive health services for pregnant/postpartum women, including assessment, education, intervention, and counseling provided by an interdisciplinary team of community health nurses, nutritionists and psychosocial workers; childbirth education, and authorization of childcare. Community health worker visits may also be provided.

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The state and federal funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) card – The forms DSHS uses to identify clients in medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were previously known as DSHS medical coupons.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

Mid-Level Practitioner - Advanced Registered Nurse Practitioner (ARNP), Certified Nurse Midwife, Woman's Health Care Nurse Practitioner, Physician's Assistant (PA), Psychiatric ARNP, Clinical Social Worker, or Mental Health Mid-Level Practitioner.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client and which consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Primary Care Provider (PCP) - A provider who provides, manages, and coordinates medical care for the *Healthy Options* enrollee. The PCP must also authorize, in advance, all health care services performed by other providers. The only exceptions to this preauthorization requirement are a medical emergency, and/or services covered by MAA but not included under the contract with the managed health care provider.

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Care Contracts;
- Provider Enrollment/Relations; and
- Regulatory Improvement.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Remittance And Status Report (RA) - A report produced by the Medicaid Management Information System (MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Regional Support Network (RSN) - A county authority or group of county authorities recognized by the secretary that enter into joint operating agreements to contract with the secretary under this chapter. (WAC 275-57-020)

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client.
(WAC 388-500-0005)

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
(WAC 388-500-0005

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

Federally Qualified Health Centers

What is a Federally Qualified Health Center?

A Federally Qualified Heath Center is a facility that is:

- Receiving grants under section 330 of the Public Health Services Act;
- Receiving such grants based on the recommendation of the Health Resources and Services Administration within the Public Health Service, as determined by the Secretary, to meet the requirements for receiving such a grant; or
- A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self-Determination Act (PL93-638).

☞ **Note:** A corporation with multiple sites may be designated as a single FQHC, or each site may be designated as an individual FQHC, depending on the designation by the Health Care Financing Administration (HCFA).

Only HCFA-designated FQHCs will be allowed to participate in the program.

What is the purpose of MAA's Federally Qualified Health Center program?

The purpose of MAA's Federally Qualified Health Center (FQHC) program is to provide covered medical services to MAA clients who require ongoing, continuous, or repetitive management of their health care.

Participation in the Medicaid FQHC program is voluntary.

- **Participating FQHCs** receive an encounter payment that includes medical services, supplies, and the overall coordination of the services provided to the MAA client.
- **Nonparticipating HCFA designated FQHCs** receive reimbursement on a fee-for-service basis.

States must reimburse FQHCs for services provided to Medicaid clients at 100 percent of the reasonable cost, as determined through established cost-finding and Medicare methodologies.

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Client Eligibility

Who is eligible for services provided in an FQHC?

- Clients with one of the following identifiers on their Medical Assistance IDentification (MAID) cards are eligible for services provided in an FQHC:

MAID Identifier	Medical Program
CNP	Categorically Needy Program
CNP-Children's Health	Children's Health Program
CNP - CHIP	Children's Health Insurance Program
Detox Only	DETOX
Family Planning Only	Family Planning
LCP-MNP	Limited Casualty Program-Medically Needy Program
GA-U No out of state	General Assistance - Unemployable

Are clients enrolled in managed care eligible for FQHC services? **[Refer to WAC 388-538-060 and 095]**

YES! Clients with an identifier in the HMO column on their MAID card are enrolled in one of MAA's Healthy Options managed care plans. All FQHC services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their PCP by calling the telephone number located on their MAID card. Clients can designate and use the FQHC as their PCP by marking this on the Healthy Options enrollment form or by calling 1-800-562-3022.

To prevent billing denials, please check the client's MAID card prior to scheduling services and at the time of service to make sure proper authorization or referral is obtained from the PCP and/or plan.

Primary Care Case Management (PCCM) clients will have the identifier PCCM in the HMO column on their MAID cards. Please make sure these clients have been referred by their PCCM prior to receiving services. The referral number is required in field 17A on the HCFA-1500 claim form. (See *Section H: Billing* for further information.)

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Encounters

What is an encounter?

An encounter is a face-to-face contact between a client and a provider of health care services who exercises independent judgement when providing health services to that client. For a health service to be defined as an encounter, it must meet specific encounter criteria (as defined on pages D4 through D7) and be documented in the client's record.

Under which medical programs does MAA reimburse encounters?

- MAA will reimburse FQHCs an encounter rate when they provide services to clients with one of the following identifiers on their MAID cards:

MAID Identifier	Medical Program Eligibility
CNP	Categorically Needy Program
Exception: If the client's MAID card shows CNP with a POB in the medical coverage group (undocumented pregnant woman) and the dates of service are on or after October 1, 1999, MAA will reimburse the FQHC fee-for-service only.)	
CNP – CHIP	Children's Health Insurance Program
Family Planning Only	Family Planning
LCP – MNP	Limited Casualty Program–Medically Needy Program

- MAA will reimburse FQHCs fee-for-service only when they provide services to clients with one of the following identifiers on their MAID cards. **An encounter will not be counted in the reconciliation process**.

MAID Identifier	Medical Program Eligibility
CNP – Children's Health	Children's Health Program
Detox Only	DETOX
GA-U No Out-of-State Care	ADATSA

How do I determine whether a service is an encounter?

To determine whether a contact with a client meets the encounter definition, all the following criteria must be met:

1. **Independent Judgement:** The provider must make an independent judgement. The provider must act independently and not assist another provider.

Examples:	
Encounter:	A mid-level practitioner sees a client to monitor physiologic signs, to provide medication renewal, etc., and uses standing orders or protocols.
Not an Encounter:	A mid-level practitioner assists a physician during a physical examination by taking vital signs, history, or drawing a blood sample.

2. **Documentation**: All services must be documented in the client's file. The client's medical visit does not have to be documented with a full and complete health record to meet the encounter criteria. Provision of emergency services may be billed as an encounter when minimal services are provided and a complete health record is not created.

3. **Each *individual* provider is limited to one type of encounter per day for each client, regardless of the services provided**.

   Example: A physician may not bill for a medical encounter and a maternity encounter for the same client on the same day. When an all-inclusive service, (e.g., CPT code 59400) is billed, the subsequent visit cannot be billed with an Evaluation and Management (E/M) code and encounter.

   A dental encounter and a physician encounter can be billed on the same day by using separate provider numbers.

   In addition, if a client visits a health center, more than one encounter will be allowed if there are separate performing providers. Each performing provider must bill separately.

4. **Encounter Locations** - An encounter may take place in the health center or at any other location (such as mobile vans, hospitals, clients' homes, and extended care facilities) in which project-supported activities are carried out.

5. **Serving Multiple Clients Simultaneously** - When an individual provider renders services to several clients simultaneously, the provider can count an encounter for each client if the provision of services is documented in each client's health record. This policy also applies to family therapy and family counseling sessions. **Bill services for each client on separate claim forms.**

Types of services that do NOT qualify as encounters

The following services are not reimbursed as an encounter. These services are reimbursed fee-for-service.

- Health services provided to clients under the following state-only programs: GAU, Children's Health, ADATSA, and DETOX.
- Blood draws, laboratory tests, x-rays, prescriptions, and/or optical services. These are not encounters, but these procedures may be provided in addition to other medical services as part of an encounter.
- Health services provided to undocumented alien S-women for dates of service on or after October 1, 1999.

☞ **Note:** Bill an appropriate encounter for ALL eligible client claims. Client eligibility may change. The MMIS will determine whether the encounter is counted in the reconciliation process.

FQHC-Related Activities NOT covered by MAA

The following circumstances are NOT covered by MAA and CANNOT be billed either as an encounter or on a fee-for-service basis:

1. Participation in a community meeting or group session that is not designed to provide health services.

   Examples: Informational sessions for prospective users, health presentations to community groups, high school classes, PTAs, etc. or, informational presentations about available FQHC health services.

2. Health services provided as part of a large-scale effort.

   Examples: Mass-immunization program, a screening program, or a community-wide service program (e.g., a health fair).

Types of Encounters

1. Medical Services Encounter (State-unique code 9000M)

A medical services encounter is a face-to-face encounter between a medical provider and a client during which services are provided for the prevention, diagnosis, treatment and/or rehabilitation of illness or injury. Included in this category are physician encounters and mid-level practitioner encounters, and encounters by psychiatrists, psychiatric ARNPs, psychologists and qualified clinical social workers who are not performing community mental health. **An encounter code and its related fee-for-service code(s) must be billed on the same claim form.**

Physician Encounter: A face-to-face encounter between a physician and a client. Psychiatrist and approved Diabetes Education Program encounters are included in this category.

Mid-level Practitioner Encounter: A face-to-face encounter between a mid-level practitioner (Advanced Registered Nurse Practitioner [ARNP], Certified Nurse Midwife, Woman's Health Care Nurse Practitioner, Physician's Assistant [PA] or psychiatric ARNP) and a client, in which the mid-level practitioner acts as an independent provider. Services provided by registered nurses are not encounters. *Multiple units are not allowed.*

2. Medical/Maternity Encounter (State-unique code 9001M)

A medical/maternity encounter is a face-to-face encounter between a medical provider and a client during which medical services are provided for prenatal care and/or delivery.

Use this encounter code when no separate encounter rate has been established for FQHCs. Physician and mid-level practitioner encounters are included in this category.

An encounter code and its related fee-for-service code(s) must be billed on the same claim form.

Physician Encounter: A face-to-face encounter between a physician and a client.

Mid-level Practitioner Encounter: A face-to-face encounter between a mid-level practitioner (ARNP-Midwife, Licensed Midwife, or PA) and a client in which the mid-level practitioner acts as an independent provider.

Multiple units may be billed with a single encounter code only in obstetrical care, dental health care, and mental health care. Support services may have multiple units if different types of services are provided.

3. Maternity Encounter (State-unique code 5900M)

A maternity encounter is an encounter between a medical provider and a client during which medical services are provided for prenatal care and/or delivery. Physician encounters and mid-level practitioner encounters are included in this category.

Use this encounter code when a separate maternity encounter rate has been established for FQHCs. **An encounter code and its related fee-for-service code(s) must be billed on the same claim form.**

Physician Encounter: A face-to-face encounter between a physician and a client.

Mid-level Encounter: A face-to-face encounter between a mid-level practitioner (ARNP-Midwife, Licensed Midwife, or PA) and a client in which the mid-level practitioner acts as an independent provider.

Multiple units may be billed with a single encounter code only in obstetrical care, dental health care, and mental health care. Support services may have multiple units if different types of services are provided.

4. Maternity Support Services Encounter (State-unique code 9006M)

For an FQHC to bill for MSS, the agency must be approved by the Department of Health, Community and Family Health, and must meet the billing policy and eligibility requirements as specified in the Maternity Support Services (MSS) Billing Instructions.

A maternity support services encounter is a face-to-face encounter between a MSS provider and a client during which MSS services are provided.

MSS includes assessment, development, implementation and evaluation of plans of care for pregnant women and their infants for up to two months postpartum. **An encounter code and its related fee-for-service code(s) must be billed on the same claim form.**

MSS Encounter: An encounter between a member of the MSS interdisciplinary team and the client. Team members may include a registered nurse, psychosocial worker, nutritionist, or a community health worker. Refer to the Maternity Support Services Billing Instructions for specific qualifications.

Multiple units may be billed with a single encounter code only in obstetrical care, dental health care, and mental health care. MSS may have multiple units if different types of services are provided. NOTE: Separate documentation must be in the client's file for each type of service provided by a mid-level practitioner.

5. Maternity Case Management Encounter (State-unique code 9007M)

For an FQHC to bill for MCM, the agency must be approved by the Department of Social and Health Services, Medical Assistance Administration, and must meet the billing policy and eligibility requirements as specified in the Maternity Case Management (MCM) Billing Instructions.

A maternity case management encounter is between a MCM provider and a client during which MCM services are provided. MCM services include a minimum of one, monthly in-person contact with a pregnant or parenting woman to develop or review the written service plan.

Use state-unique procedure code 0081M for documented attempts to contact client, but no in-person contact was made during the month (allowed once every three months until the baby's first birthday). **An encounter code and its related fee-for-service code(s) must be billed on the same claim form.**

MCM Encounter: A face-to-face encounter between a maternity case manager and a client. A maternity case manager is either a professional or paraprofessional under the direct supervision of a professional, employed by an MCM-approved provider. Maternity case managers may be nurses, social service workers, paraprofessionals, or substance abuse counselors. Refer to the Maternity Case Management Billing Instructions for specific qualifications. *Multiple units are not allowed.*

6. Dental Services Encounter (State-unique code 0200D)

For an FQHC to bill for dental, the agency must be approved by DSHS – MSS and must meet the billing and eligibility requirements as specified in the Dental Program Billing Instructions.

A dental encounter is a face-to-face encounter between a dentist, or a dental hygienist, and a client for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. **Only one encounter is allowed per day.**

☞ **Note:** A dental hygienist may bill an encounter only when he/she provides a service independently - not jointly with a dentist. Only one encounter per day at a dental clinic is covered.

Exception: When a dental service requires multiple visits (e.g., root canals, crowns, dentures), an encounter code must be billed with the number of visits for the dental services are complete.

Multiple units may be billed with a single encounter code only in obstetrical care, dental health care, and mental health care.

7. Mental Health Encounter (State-unique code 9701M)

To provide mental health services, the agency must be a licensed community mental health center and have a contract with a Regional Support Network (RSN). Included in this category are mental health professionals (as defined in WAC 275-55-020(33)). **Use state-unique encounter code 9701M only for community mental health services capitated clients.**

Use state-unique encounter code 9000M if a clinic is not a licensed community mental health center, mental health encounters provided by a psychiatrist, psychologist, psychiatric ARNP, or a qualified clinical social worker.

A mental health encounter is face-to-face between a mental health provider and a client during which services are provided for the diagnosis and treatment of a Diagnostic and Statistical Manual-3 (DSM-3R) psychiatric condition.

Psychiatrist and Psychologist Encounters: An encounter between a client and a physician or osteopath licensed under chapter 18.57 or 18.71 RCW, who is board-eligible in psychiatry or a psychologist licensed under chapter 18.83 RCW.

Multiple units may be billed with a single encounter code only in obstetrical care, dental health care, and mental health care.

(Fee for service encounter code 9700M has been deleted.)

Mid-level Practitioner Encounter: An encounter between a mid-level practitioner and a client in which the mid-level practitioner acts as an independent provider. A mid-level practitioner is:

A. A psychiatric nurse, which means a registered nurse licensed under chapter 18.88 RCW and who has at least two years' experience in the direct treatment of mentally ill individuals under the supervision of a mental health professional.

B. A social worker, which means a person with a master's or further advanced degree from an accredited school of social work or a degree from a graduate school deemed equivalent by the DSHS Secretary.

C. A person who has at least a master's degree in behavioral sciences, nursing sciences, or related field from an accredited college or university and who has at least two years' experience in the direct treatment of mentally ill individuals under the supervision of a mental health professional.

D. A mental health counselor or marriage and family therapist certified under chapter 18.19 RCW and who has at least two years' experience in the direct treatment of mentally ill individuals under the supervision of a mental health professional; OR

E. A person who has at least a bachelor's degree in behavioral sciences or related field from an accredited college or university and who has at least five years' experience in the direct treatment of mentally ill individuals under the supervision of a mental health professional.

8. Chemical Dependency Treatment Programs **(State-unique code 9005M)**

A FQHC treatment facility must be approved by DSHS pursuant to WAC 440-22 and RCW 70.96A. FQHCs may only bill for those services as listed in the Chemical Dependency Billing Instructions.

Use state-unique encounter code 9005M when billing for these services.

A chemical dependency encounter is between a medical provider and/or Qualified Chemical Dependency Counselor (QCDC), as defined in WAC 440-22-200 through 250, and a client, during which services are provided for outpatient alcohol and drug treatment services.

FQHC Reimbursement

The Reimbursement Structure

The FQHC reimbursement structure is based on a per encounter basis, with individual encounter rates established for each FQHC. In order to calculate the difference between the encounter rate and the fee-for-service payment, providers must submit their claims to MAA using the appropriate fee schedules.

A monthly reconciliation is done between:

- The amount owed (the number of encounters indicated on the paid claim forms multiplied by the encounter rate); and
- The amount reimbursed based on the fee-for-service methodology.

For information or questions regarding cost and audit reports, call (360) 725-1840.

For information on pharmacy reimbursement, refer to MAA's Prescription Drug Program billing instructions located at http://maa.dshs.wa.gov (Billing Instructions link) or call the Provider Relations Unit at 1-800-562-6188 to request a hard copy.

Bill Claims with Related Encounters

- **Always** list an encounter code on the same claim as its related fee-for-service procedure codes. **NEVER BILL AN ENCOUNTER CODE BY ITSELF**, except for the Mental Health encounter state-unique code 9701M. See page D.7 for specific information on Mental Health encounters.

- When billing the encounter code, do not include an encounter rate. The billing amount should be listed as $0.00, as shown on the attached sample claim forms.

- MAA will deny Evaluation and Management (E&M) services (CPT 99201-99215) that are not billed with an encounter code.

> **Exception:** E&M CPT codes 99201 and 99211 can be billed without an encounter code for immunization services provided by registered nurses.

- When billing for services that do not qualify as an encounter (see page D.3 for examples) do not use an encounter code on the claim form.

> ☞ **Note:** Bill an appropriate encounter for ALL eligible client claims. Client eligibility may change. The MMIS will determine whether the encounter is counted in the reconciliation process.

Choice of Rates

FQHCs may elect to have either an all-inclusive rate, which covers all Title XIX services, or individual rates for different types of service.

- For FQHCs choosing an all-inclusive rate, this rate will be applied to each of the encounter codes.
- For FQHCs choosing the individual rates, the rates will be applied according to the appropriate encounter code.

Multiple Provider Numbers

Each FQHC will be assigned a provider number. A FQHC must use the provider number(s) to receive payment under the FQHC reimbursement system. If the facility is a multi-service facility, it will be issued a provider number for each type of service provided. For instance, a facility which provides medical, dental, and pharmacy services will be issued three provider numbers. If an FQHC has several clinic sites, a provider number may be issued for each site.

When adding a new clinic or service, indicate on the Core Provider Agreement that you are an FQHC.

Procedure Codes

FQHCs *must* submit claims using the appropriate procedure codes listed in the following billing instructions, as applicable:

Chemical Dependency	Maternity Support Services
Dental Program	Physician-Related Services (RBRVS)
Maternity Case Management	Prescription Drug Program

Claims must be submitted on the appropriate claim form:

- Medical services, Maternity Support Services, Maternity Case Management, Chemical Dependency, and Mental Health on the HCFA-1500 claim form.
- Dental services on the ADA Dental Form.
- Pharmacy claims on the Pharmacy Statement Claim Form 525-106.

How Payment is Calculated

At the end of each month, MAA will make a *reconciliation payment* to each FQHC based on the number of encounters that occurred during the month minus the fee-for-service payments made during the month.

For example:	$80.00	Medical Encounter Rate
	x 50	# of Medical Encounters for Month
	= **$4,000.00**	***Total Reimbursement***
	- 3,000.00	Fee-for-Service Payment for Month
	= **$1,000.00**	***Provider's Reconciliation Payment***

Bill Fiscal Years Separately

Please make sure that the dates of service on claims do not span the end of one FQHC fiscal year into the beginning of the next. If this occurs, MAA's monthly reconciliation reports could contain payments allocated to the wrong fiscal year.

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Cost Reporting Requirements

Covered Health Services

Services, as defined in the Title XIX State Plan or as defined in Section 1861 (aa)(1)(A)-(C) which lists FQHC required core services, are covered when they are required for:

- The ongoing, continuous, or repetitive management of patient's health care inclusive of services and supplies; and
- The overall coordination of all services provided to the patient.

Noncovered Health Services

Services that are offered by the FQHC, but not required by either Department of Health and Human Services and/or not included in the Title XIX State Plan.

Non-Reimbursable Services

- Women, Infants and Children (WIC) Program - MAA reimburses for nutritional assessments and/or nutritional counseling in the WIC program only when the service is part of the EPSDT program. Costs for nutritional assessment and/or nutritional counseling are allowed under the following circumstances only:

  Children's Initial Nutritional Assessment
  The WIC program requires an initial assessment. If an initial health assessment is performed by an EPSDT (Healthy Kids) provider, this information may be used to complete the paperwork for the WIC assessment instead of WIC repeating the process. MAA will reimburse for this service when performed as part of an EPSDT screening.

  Children's Second Nutrition Education Contact
  The WIC program requires a second nutrition education contact that is reimbursed by WIC funds. If the child is determined to be at nutrition high-risk, WIC requires that a nutrition high-risk care plan be written. The nutrition high-risk care plan written by the certified dietitian through an EPSDT referral may be used to meet the requirement of the WIC nutrition high-risk care plan. MAA will reimburse for nutritional counseling only when it is an EPSDT referral.

Pregnant women in the WIC program are required to have an initial assessment and a second nutrition education contact which is reimbursed by WIC funds. If additional nutritional counseling is required and performed as part of Maternity Support Services (MSS), the additional nutritional counseling will be reimbursed by MAA.

- Education, except for training and staff development required to enhance job performance for employees of the clinic.
- Outreach, except for the following type of activities: informing target population of available services, such as telephone yellow pages, brochures, and handouts.
- Assisting other health care professionals in the provision of off-site training, such as dental screening, blood pressure checks.
- Public relations, such as assisting a client in dealing with another agency and/or provider.
- Community services, such as health presentations to community groups, PTAs.
- Environmental activities designed to protect the public from health hazards such as toxic substances, contaminated drinking water and shellfish.
- Research.
- Non-emergent patient transportation to and from the FQHC and provided by the clinic.
- Services that are performed by a subcontractor of the FQHC; include, but are not limited to laboratory, x-ray and pharmacy.
- Services such as hospital care, skilled nursing care, home health services, rehabilitative services, mental health services inpatient or outpatient that are provided on an inpatient basis.
- Services that are not directly provided by the clinic.

Allowable Costs

Allowable costs are:

Documented costs as reported after any cost adjustment, cost disallowances, reclassifications, or reclassifications to nonallowable costs which are necessary, ordinary and related to the outpatient care of medical care clients and are not expressly declared nonallowable by applicable statutes or regulations. Costs are ordinary if they are of the nature and magnitude which prudent and cost-conscious management would pay.

Covered Direct Health Care Costs (DHCC)

Costs that can be identified specifically with a particular final cost objective. These costs must be directly related to patient care.

Examples of DHCC include, but are not limited to:

- Medical record and medical receptionist costs; and
- Dues for personnel to professional organizations that are directly related to the individual's scope of practice. **Limited to one professional organization per professional**.

Overhead Costs

Overhead costs are those that have been incurred for common or joint objectives and cannot be readily identified with a particular final cost objective.

Examples of overhead costs are:

- Billing department expenses that do not meet the definition under Uncapped Overhead on next page.
- Space costs that do not meet the definition under Uncapped Overhead on next page.
- Dues to industry organizations. Limited to those dues that are not grant funded or used by organizations for lobbying activities. **Limited to one industry organization per clinic**.
- Interpreter services. Interpreters are reimbursed directly by the FQHCs. The FQHCs will bill Medical Assistance Administration (MAA) directly. Costs associated with billing for interpreter services are allowed on the cost report.
- Costs related to Basic Health Plus premiums.
- Costs associated with employees who verify managed care eligibility.

Uncapped Overhead

Overhead costs that are allocated must be:

- Clearly distinguished from other functions; and
- Clearly identified as a benefit to a direct service.

Costs that can be included in this cost center are:

- Space costs, which are defined as building depreciation, mortgage interest, and facility lease costs. The FQHC is required to have a reasonable floor space allocation plan that adequately documents facility usage. At least 25 percent of the facility would have to be used for a direct cost function (i.e., medical).

- Billing department costs that are separate and distinct functions of the FQHC for the purpose of billing for medical care only. Staff must be solely dedicated to medical billing, and duties must be assigned in advance.

Cost Disallowances

Costs will be disallowed if not documented, necessary, ordinary and related to the provision of care and services to authorized patients. Cost disallowances include but are not limited to the following:

- **Entertainment** (e.g., office parties/social functions, costs for flowers, cards for illness and/or death, retirement gifts and/or parties/social functions, meals and lodging) These costs cannot be included as a part of employee benefits.
- **Board of Director Fees** – Travel expenses related to mileage, meal, and lodging costs to conferences and registration fees for such meetings if not related to operating the clinic; (e.g., clinic-sponsored annual meetings, retreats, and seminars). Reimbursement level based on the lesser of actual costs or state travel regulations.
- **Federal, state, and other income taxes and excise taxes**.
- **Medical Licenses** – Costs of medical personnel professional licenses.
- **Costs associated with the use of temporary health care personnel** from any nursing pool not registered with the Department of Licensing at the time of such pool personnel use.
- **Costs for subcontracts (referred services**) From example: costs for laboratory, x-ray, and pharmacy subcontracts the clinic has for the performance of support services. The laboratory, x-ray facility or pharmacy bills MAA directly and is reimbursed directly by MAA.
- **Donations, services, goods, and space** except those allowed in Circular A-122 and the Medicare Provider Reimbursement Manual.

- **Fines and penalties.**
- **Bad debts and costs of actions by outside staff or agencies to collect receivables**.
- **Advertising,** except for the recruitment of personnel, procurement of goods and services, and disposal of medical equipment and supplies.
- **Contingency reserves** except for those items legally mandated or identifiable to a specific allowable liability.
- **Legal, accounting, and professional services** incurred in connection with hearings and rehearings, arbitrations, or judicial proceedings against the department.
- **Fund raising.**
- **Amortization of goodwill.**
- **Membership dues for public relations** except for those allowed as a direct health care covered cost or overhead cost.
- **Political contributions.**
- **Costs allocable to the use of a vehicle for personal use**.
- **Costs applicable to services, facilities, and supplies** furnished by a related organization in excess of the lower of cost to the related organization or the price of comparable service.
- **Vending machine expenses.**
- **Charitable contributions.**
- **Costs not related to patient care.**
- **Outstationed financial workers** provided by Community Service Offices (CSO). CSO makes the final decision on whether or not to outstation CSO staff based on an evaluation of the level of Medicaid activity and resources available. When CSO staff are outstationed in a FQHC, a written agreement between the CSO and the FQHC spelling out the responsibilities of each is required.
- Grants that are for specific targeted programs received from federal, state, county and/or city sources. Examples of these types of grants are: School Teen Health Centers, Breast Cancer Screening and HIV. This does not include the grants received under Section 330 of the Public Health Services Act.

Audit

- **Standards** – The following regulations are the audit standards applicable to the FQHC cost reimbursement program in order of precedent:

  - ✓ 42 CFR Section 413;
  - ✓ MAA policies and definitions;
  - ✓ Circular A-122 "Cost Principles for Nonprofit Organizations;" and
  - ✓ Medicare Provider Reimbursement Manual.

- **Documentation** – Documentation must be available for the auditors in the client's medical record at the clinic. Separate maternity and medical records must not be kept at different locations. Until a chart is established for a newborn, when a physician sees the baby, this encounter must be clearly documented in the mother's record.

Cost Reports

- **Submission** – When enrolling in the FQHC reimbursement program, the first cost report period is the most current actual 12-month period coinciding with the facility's fiscal year end. Subsequent reporting periods will be based on the FQHC's fiscal year end and must be submitted no later than 120 days after the end of the fiscal year.

  - ✓ For cost **reports received between the first and the 15th of the month**, FQHC cost reimbursement will become effective the first day of that month.

  - ✓ For those **reports received after the 15th of the month**, the effective date of FQHC cost reimbursement will be the first day of the subsequent month.

- **Complete list of providers** for all programs during the cost report period must be included with the cost report. The list must state each provider's specialty and the license number and expiration date.

- **Cost settlements** – A cost settlement audit will be performed each year based on the submitted cost report. This report will be used in auditing the prior year and establishing interim encounter rates for the new year.

- If a final settlement determines that an **FQHC received overpayments or payments in error**, the FQHC must refund such payments to MAA within thirty days after receipt of the final settlement letter. Monthly repayments up to one year may be requested. If granted by MAA, an interest rate of one percent per month on the unpaid balance will be assessed. Each FQHC's fiscal year audit settlement cannot be carried forward to the next fiscal year.

- If MAA determines that an **FQHC received underpayments**, MAA will reimburse such payments within 30 days from the receipt of the final settlement letter.

Full-Time Equivalent (FTE)

To determine FTEs, the total number of hours paid for the year is divided by 2080. FTEs for temporary, part time, and contracted including non-paid physician time, are to be included on worksheets 2A-2E, column 1, on the Cost Report.

On-Call

- **Productivity Calculation**

  On-call FTEs and encounters for determining minimum productivity for medical and maternity services is based on the specific clinic agreement. The agreements must be documented. The policy under the FTE section on previous page applies to how applicable FTEs are determined.

  For the following types of on-call, the criteria are:

  ✓ Clinic staff who are assigned on-call as part of their normal duties and receive no additional compensation for the on call: FTEs are calculated using the total hours paid. Total encounters are used in the minimum productivity calculation;

  ✓ Clinic staff who are assigned to on call as part of their normal duties and receive additional compensation for on call: FTEs are calculated using the hours paid at regular salary. Only the encounters associated with the regular hours paid are used in the minimum productivity calculation; and

  ✓ Contract staff who perform both regular and on-call duties: FTEs are calculated using the hours paid for the regular duties. Only the encounters associated with the regular duties are used in the minimum productivity calculation.

- **Encounter Rate Calculation**

  Total (on-call and regular) staff expenses must be included on the Cost Report. The total encounters for regular and on-call must be included on Worksheets 2A-2E on the Cost Report and used in calculating the encounter rate.

  To verify the patients and associated number of encounters that physicians and mid level practitioners have seen, the clinic must have records which substantiate the number of encounters by:

  ✓ Physicians and mid-levels practitioners who receive additional compensation for their on-call time; and
  ✓ Contract physicians and mid-levels during on-call time.

Productivity Determination

Minimum medical team productivity is calculated for Medical and Maternity Services. Total Medical Team FTEs (shown on worksheets 2A-2E, Part B, 2 on the Cost Report) are multiplied by 3,600 and compared to the FQHC's on-site encounters and, under specific circumstances, off-site encounters. Off-site encounters may be included only when provided at a regularly scheduled place. Psychiatrists are medical doctors and must meet FTE requirements.

Test of Reasonableness for Salaries

Reasonableness of salaries will be tested against the Washington State Department of Personnel Biannual Salary Survey and Compensation Plan enhanced to 120 percent to recognize the practice of the legislature of paying state salaries at 80 percent of private salaries.

Consideration will be given to higher salary levels due to unusual circumstances and exceptions may be granted at the auditor's discretion in consultation with MAA.

Cost for Contracted Physician Services

Costs for contracted physician services are included in the Cost Report. Physicians must be identified in the FQHC's Core Provider Agreement. The physician is a preferred provider and receives an identification number from the Provider Enrollment Section at MAA.

Border Area FQHCs

Border area FQHCs must either enroll in both states' programs or continue to be reimbursed as a non-FQHC.

Corporations with Multiple Sites

Corporations with multiple sites may be designated as a single FQHC or each site may be an individual FQHC, depending on the designation by HCFA and the Public Health Service.

Inpatient Services

All inpatient services (e.g., physicians' services for OB) must be included in the cost report.

Depreciation

- For items purchased on or before August 30, 1997, the following rules apply:

  - ✓ If the original purchase price is $1,000 or more, it must be depreciated.
  - ✓ Older equipment may be expensed (depreciated) over a three-year period.

- For items purchased on or after September 1, 1997, the following rules apply:

  - ✓ If the total unit purchase price is $4,999 or less, it is considered current operating costs and do not have to be depreciated. These items can be expensed (depreciated) in the year of purchase.

  - ✓ Land, buildings, equipment permanently attached or an integral part of a building and small attractive items must be depreciated using American Hospital Association (AHA) guidelines. Examples of small attractive items are cellular telephones and computer components.

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Diabetes Education Program

Only FQHCs, clinics, or outpatient hospitals can apply to be a Diabetes Education Program provider. Follow the policies and procedures outlined in this section.

Application Process

1. Obtain a Diabetes Education Program Application and Reference List from:

   Health Promotion Specialist
   Diabetes Control Program
   Department of Health
   PO Box 47836
   Olympia, WA 98504-7836
   (206) 872-2953

2. Provide the following documentation with the application:

   Primary Health Care Advisor;
   Referral process;
   Qualifications of, and continuing education gained by, the teaching team; and
   Curriculum outlined by module.

Program Requirements for Initial Application

1. Complete the application and receive program approval from the Diabetes Control Program, Department of Health (refer to Application Process above).

2. The program must have an appropriate Primary Health Care Advisor (a physician, Advanced Registered Nurse Practitioner [ARNP], or physician assistant [PA]) who is responsible for the oversight of the program.

3. The program must have a multidisciplinary diabetes educational team.

4. Programs must be taught by the appropriate licensed or registered health care provider (RN, LPN, RD, MD, ARNP, RPh, or PT). This provider must have at least six hours of diabetes-specific continuing education within the last two years or must be a Certified Diabetes Educator. Proof of licensure, registration or certification and continuing education must be documented for each team member.

5. The program curriculum must address the following core modules:

   - **Nutrition**: an individualized meal plan instruction that is not part of the Women, Infants, and Children (WIC) program.
   - **Exercise**: an individualized physical activity (exercise) plan.
   - **Prevention of Acute Complications**: including hypoglycemia, hyperglycemia, and sick day management.
   - **Prevention of Chronic Complications**: including retinopathy, nephropathy, neuropathy, cardiovascular disease, foot and skin care.
   - **Monitoring**: immediate and long-term diabetes control such as glucose, ketones, and glycosylated hemoglobin.
   - **Medication**: such as oral agents and insulin, including insulin start-up.

6. The following documentation must be included when the initial application is submitted for program approval:

   - Name and licensure of the medical advisor who is responsible for the oversight of the program.
   - Names, and licensure, registration, or certification of the multi-disciplinary diabetes educational team.
   - Name of the diabetes program coordinator.
   - Documentation for each team member of at least six (6) hours of diabetes specific continuing education received within the last two years, or documentation of current status as a Certified Diabetes Educator.
   - Diabetes education teaching curriculum, in outline format with measurable, behavioral-stated educational objectives.
   - Client needs assessment form, used to determine what education is appropriate for that client.

7. To maintain approval, diabetes education programs must submit the following documentation each year during the month of January:

   - Name and licensure of the medical advisor who is responsible for the oversight of the program.
   - Names and licensure, registration and/or certification of the multi-disciplinary diabetes education team.

8. Diabetes education programs must renew approval by sending the following documentation every three years:

   - Name and licensure of the medical advisor who is responsible for the oversight of the program.
   - Names, and licensure, registration, or certification of the multi-disciplinary diabetes educational team.
   - Name of the diabetes program coordinator.
   - Documentation for each team member of at least six (6) hours of diabetes specific continuing education received within the last two years.
   - Diabetes education teaching curriculum, in outline format with measurable behaviorally stated educational objectives.

Billing/Reimbursement Requirements

1. The client must be referred by a licensed primary health care provider. Bill the appropriate E/M procedure code for the initial counseling session.

2. A minimum of one hour of education **must** be taught per billed module. Any combination of the core modules may be taught to meet the individual needs of the client. Bill the procedure code that represents the major content area.

3. A maximum of six hours per calendar year of individual core modules in any combination are allowed per client. For example, a person starting insulin may receive two hours (units) of the medication module, two hours (units) of nutrition, one hour (unit) of acute complications, and one hour (unit) of monitoring.

4. Individualized or group clinic diabetes education services are reimbursed at $45.00 per client for each individual module.

5. The applicable procedure codes and reimbursement rates are as follows:

CORE MODULE	PROCEDURE CODE	REIMBURSEMENT RATE
Nutrition	1650M	$45.00
Exercise	1651M	$45.00
Prevention of Acute Complications	1652M	$45.00
Prevention of Chronic Complications	1653M	$45.00
Monitoring	1654M	$45.00
Medication Management	1655M	$45.00

6. Bill procedure codes on the HCFA-1500 claim form, and use only the procedure codes listed on previous page. **Only the clinic can bill for diabetes education. Individual instructors cannot bill for diabetes education. Use the main clinic provider number with the individual practitioner's provider identification number**.

7. Bill units in hourly increments.

General Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timelines standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that affects the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

  ☞ **Note:** If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date the plan recouped the payment from the provider.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients:

- Enter the Primary Care Case Manager (PCCM) name in field 17 on the HCFA-1500 claim form; and

- Enter the seven-digit identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

☞ **Note: Newborns of Healthy Options clients that are connected with a PCCM are fee-for-service until the client has chosen a PCCM for the newborn. All services should be billed to MAA.**

What records must be kept? [WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for six years from the date of service or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.

How do I bill for clients eligible for Medicare and Medicaid?

Services provided to clients who have Medicare and Medicaid coverage **do not qualify** for an additional encounter payment **unless Medicare does not cover the service**.

When you have a client who is eligible for both Medicare and Medicaid, you must submit your claims for that client to your Medicare intermediary or carrier **first**. **Medicare is the primary payor**.

An "X" in the Medicare column on the client's Medical Assistance IDentification (MAID) card indicates Medicare enrollment.

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.
- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

For QMB-Medicare Only:
If **Medicare does not cover the services**,
MAA will not reimburse the service.

FQHCs Previously Categorized Under Title XIX As Rural Health Centers (FQHCs who bill Medicare encounter codes)

- Indicate *Medical Assistance* and include the patient identification code (PIC) as shown on MAID card, on the claim form. Enter the Medical Assistance provider number.
- Accept assignment.
- If Medicare has allowed the service, in most cases Medicare will forward the claim to MAA. MAA then processes your claim for any supplemental payments.
- If Medicare does not forward your claim to MAA **within 30 days** from its statement date, send a copy of the UB-92 claim form and a copy of Medicare's Explanation of Medical Benefits (EOMB) to MAA for processing. **You must use the Medicare crossover provider number MAA has assigned to you.** Please refer to "How to Complete the UB-92 Medicare Part B/Medicaid Crossover Claim Form", Section L.
- When Part A services are totally disallowed by Medicare but are covered by MAA, bill MAA on the UB-92 claim form and attach copies of Medicare's EOMB with the denial reasons.

FQHCs Not Previously Categorized Under Title XIX As Rural Health Centers (FQHCs who bill using the Physician Related Services Billing Instructions)

[FQHCs Billing Resource Based Relative Value Scale (RBRVS)]

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do no submit paid lines with denied lines. This could cause a delay in payment.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment. **Attach the EOMB and indicate the appropriate encounter code, if the services qualify as an encounter.**

- If Medicare denies a service that requires prior authorization by MAA, MAA will waive the prior authorization requirement but will still require authorization. Authorization or denial of your request will be based upon medical necessity.

  NOTE:

  - ✓ Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.
  - ✓ A Medicare Remittance Notice or EOMB must be attached to each claim.

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Rebillings and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

Rebillings

You should **rebill** when:

- **The claim is denied in full**. When the entire claim is denied, check the Explanation of Benefits (EOB) code, then make the appropriate corrections and resubmit your claim on a regular billing form, not the adjustment form.

- **An individual line is denied on a multiple-line claim**. The denied service may be submitted as a rebill on a regular billing form, not an adjustment form.

- **The claim is returned separately.** Occasionally, MAA is unable to process your claim and will return it to you with a letter stating what information is needed. Correct the information as directed and resubmit your claim.

How to Rebill

- Check any EOB code listed then make your corrections on a copy of the claim OR produce a new claim with the correct information.

- Attach insurance information to the corrected claim and send it to MAA.

  Note: Remember to line out or omit all lines that have already been paid on the claim before sending it back to MAA. Be sure to adjust the total.

If you rebill the claim after the billing time limit has expired, or more than 365 days from the original date(s) of service on the claim, enter the 17-digit claim number in field 22 (HCFA-1500) or in the claim area (UB-92). This claim number is proof of your timeliness.

NOTE: **If 60 days (or more)** have elapsed since you sent your claim to MAA *and* it has not appeared on your Remittance and Status Report, resubmit your claim.

Adjustments

You should adjust the claim if:

- **The encounter code was omitted or erroneously** reported on a paid claim. (See the sample of an adjustment request form on next page.)

- **You were underpaid.** Line items or claims paid at an amount less than MAA's maximum allowable constitute an adjustment. (If your charges are less than the maximum allowable, MAA will pay your claim as billed.)

- **You were overpaid.** See how to adjust claims below.

All **adjustments** must be submitted on the **Adjustment Request form 525-109**. Use only *one* adjustment request form per claim. Multiple line corrections to a single claim should be submitted on one adjustment request form. Adjustments are processed in two steps:

1. The MMIS locates the claim you wish to adjust. The message *CRE* will appear in the EOB column on the MAA Remittance and Status Report.

2. The action requested will be completed and the claim processed accordingly. (Requesting an adjustment does not necessarily mean that your claim will be paid.) The adjusted claim may be denied if MAA's original payment was correct or if the information provided on the Adjustment Request is incorrect.

Be sure proper documentation (e.g., operative report, Remittance and Status Report, etc.) is attached to your adjustment request to avoid another denial or incorrect disposition of your claim.

How To Adjust Overpayments

- Submit an adjustment: MAA recoups your claim and deduct the excess amount from your future remittance check(s) until the overpayment is satisfied;
  OR
- Issue a refund check payable to DSHS: Attach a copy of the Remittance and Status Report showing the paid claim and include a brief explanation for the refund (e.g., insurance payment, duplicate payment).

  Mail this to:

Office of Financial Recovery - Med
PO Box 9501
Olympia WA 98507-9501

Do one or the other, not both for same claim!

525-109 SAMPLE CLAIM FORM - ENCOUNTER OMITTED

525-109 SAMPLE CLAIM FORM - ERRONEOUS PROCEDURE CODE

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- All information must be centered within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

Field Description

1a. **Insured's ID No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each MAA client consisting of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9A. Enter the other insured's policy or group number *and* his/her Social Security Number.

9B. Enter the other insured's date of birth.

9C. Enter the other insured's employer's name or school name.

9D. Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.

11A. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11B. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11C. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11D. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the primary physician.

17A. **ID Number of Referring Physician**: When applicable, enter the 7-digit MAA-assigned primary physician number.

19. When applicable. If the client has no Part A coverage, enter the statement "Client has Medicare Part B coverage only" in this field.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this claim is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the *Remittance and Status Report*.)

23. **Prior Authorization Number**: When applicable. If the service or equipment you are billed for requires authorization, enter the 9-digit number assigned to you. Only one authorization number is allowed per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., August 04, 2000 = 080400).

24B. **Place of Service**: Required. These are the only appropriate code(s) for Washington State Medical Assistance:

Code Number	To Be Used For
1	Inpatient hospital
2	Outpatient hospital
3	Office or ambulatory surgery center
4	Client's residence
5	Emergency room
6,7,&8	Nursing home
9	Other

24C. **Type of Service**: Required. Enter a 3 for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate Current Procedural Terminology (CPT) or HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed.

Modifier: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units (up to 999) for each line. These figures must be whole units.

25. **Federal Tax ID Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your *Remittance and Status Report* under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N.: This is the seven-digit number assigned to you by MAA for:

A. An individual practitioner (solo practice); **or**
B. An identification number for individuals only when they are part of a group practice (see below).

Group: This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number. NOTE: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

HCFA-1500 – MEDICAL SERVICES ENCOUNTER

HCFA-1500 – MEDICAL/MATERNITY ENCOUNTER

HCFA-1500 – MEDICAL/MATERNITY ENCOUNTER TRIMESTER

HCFA-1500 – MATERNITY ENCOUNTER

HCFA-1500 MATERNITY SUPPORT SERVICES

HCFA-1500 – MATERNITY CASE MANAGEMENT ENCOUNTER

HCFA-1500 – MENTAL HEALTH ENCOUNTER

HCFA-1500 CHEMICAL DEPENDENCY TREATMENT PROGRAM

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Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark "XO," in box 19 on crossover claim?

A: The "XO" allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

Q: Where do I indicate the coinsurance and deductible?

A: You must enter the total combined coinsurance and deductible in field 24D on each detail line on the claim form.

Q: What fields do I use for HCFA-1500 Medicare information?

A:

In Field:	**Please Enter:**
19	an "XO"
24D	total combined coinsurance and deductible
24K	Medicare's allowed charges
29	Medicare's total deductible
30	Medicare's total payment
32	Medicare's EOMB process date, and the third-party liability amount

Q: When I bill Medicare denied lines to MAA, why is the claim denied?

A: Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate "XO."

Q: How do my claims reach MAA?

A: After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the words, *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer.

If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance and Status Report within 30 days of the Medicare statement date, you should bill MAA on the HCFA-1500 claim form.

If **Medicare denies** a service, bill MAA using the HCFA-1500 claim form. Be sure the Medicare denial letter or EOMB is attached to your claim to avoid delayed or denied payment due to late submission.

REMEMBER! You must submit your claim to MAA within six months of the Medicare statement date if Medicare has paid or 365 days from date of service if Medicare has denied.

How to Complete the HCFA-1500 Claim Form for Medicare Part B / Medicaid Crossovers

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

> The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

FIELD DESCRIPTION

1a. **Insured's I.D. No.:** Required. Enter the MAA Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification (MAID) card. This information is obtained from the client's current monthly MAID card consisting of:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

2. **Patient's Name:** Required. Enter the last name, first name, and middle initial of the MAA client (the receiver

of the services for which you are billing).

3. **Patient's Birthdate:** Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial):** When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address:** Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name:** Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number:** Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

11a. **Insured's Date of Birth:** Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name:** Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name:** Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

19. **Reserved For Local Use: Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission:** When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.**

24A. **Date(s) of Service:** Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., August 4, 2000 = 070400). **Do not use slashes, dashes, or hyphens to separate month, day or year (MMDDYY).**

24B. **Place of Service:** Required. Enter a 3.

24C. **Type of Service:** Required. Enter a 3.

24D. **Procedures, Services or Supplies CPT/HCPCS: Required. Coinsurance and Deductible:** Enter the total combined and deductible for each service in the space to the right of the modifier on each detail line.

24E. **Diagnosis Code:** Enter appropriate diagnosis code for condition.

24F. **$ Charges:** Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days Or Units:** Required. Enter 1.

24K. **Reserved for Local Use:** Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.:** Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment:** ***Required.*** Check **yes**.

28. **Total Charge:** Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid:** Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due:** Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered:** Required. Enter Medicare Statement Date *and* any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #:** Required. Enter the individual number assigned to you by MAA.

Sample Medicare Part B/Medicaid Crossover Form

How to Complete the UB-92 Medicare Part B/Medicaid Crossover Claim Form

(Use these instructions when submitting claims for dual-eligible [Medicare/Medicaid] clients.)

You must submit the Medicare/Medicaid billing form UB-92, along with a copy of your Explanation of Medicare Benefits (EOMB) to:

Division of Program Support
PO Box 9246
Olympia WA 98507-9246

The numbered boxes on the claim form are referred to as ***form locators***. *Only form locators that pertain to MAA are addressed here.*

Complete the UB-92 claim form in the usual manner required by MAA; however, there are form locators that need specific information indicated in order to process your claim. See the following instructions and claim form samples.

FORM LOCATOR, NAME AND INSTRUCTION FOR COMPLETION

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Support (DPS).

3. **Patient Control No**. - This is a 20-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** - Enter **131.**

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's MAID card.

13. **Patient's Address** - Enter the client's address.

14. **Patient's Birthdate** - Enter the client's birthdate.

39-41. **Value Codes and Amounts**

39A: **Deductible**: Enter the code *A1*, and the deductible as reported on your EOMB.

39D: **ENC Rate**: Enter Med's ENC rate as reported on the EOMB.

40A: **Coinsurance**: Enter the code *A2*, and the coinsurance as reported on your EOMB.

40D: **Encounter Units**: Enter the encounter units Medicare paid, as reported on EOMB.

41A: **Medicare Payment**: Enter the payment by Medicare as reported on your EOMB.

41D: **Medicare's Process Date**: Enter the date that Medicare processed the claim, as reported on your EOMB in numerals only (*MMDDYY*).

42. **Revenue Code** - Enter *001* for total charges on line 23 of this form locator.

43. **Procedure Description** - Enter a narrative description of total charges.

46. **Units of Service** - Enter the number of units billed per line.

47. **Total Charges** - Enter the total of this column as the last detail on line 23. Make sure the total charges on the UB-92 match the total charges billed to Medicare.

50. **Payer Identification: A/B/C** - Enter if all health insurance benefits are available.

50A: Enter *Medicaid*.
50B: Enter the name of other insurance.
50C: Enter Medicare.

51. **Provider Number** - Enter the provider number issued to you by the payor.

51A: Enter the seven-digit MAA provider number that appears on your Remittance and Status Report.
51B: Enter your Medicare provider number.

60. **Cert-SSN-HIC-ID No.** - Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each MAA client - exactly as shown on the MAID card. This information is obtained from the client's current monthly MAID card and consists of the client's:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d. An alpha or numeric character (tiebreaker).

67. **Principal Diagnosis Code** - Enter the ICD-9-CM diagnosis code describing the principal diagnosis.

SAMPLE OF FQHC USING ALL INCLUSIVE ENCOUNTER CODES ON UB-92 FOR CROSS-OVERS

How to Complete the American Dental Association (ADA) Claim Form

General Information

- Include any required prior authorization number. Prior authorized claim originals must be completed and returned as the billing document.
- Send only one claim form for payment. If the number of services exceeds one claim form, a second form can be submitted. Please make sure that all necessary claim information (provider number, patient identification code, etc.) is repeated on the second form. Each claim form should show the total charges for the services listed.
- **Enter your patient account number in the area directly below the picture of the teeth.**
- These instructions only address those fields that are required for billing MAA.

Send your claims for payment to:

Division of Program Support
PO Box 9253
Olympia WA 98507-9253

Field **Description**

4. **Patient Name:** Enter the patient's first name, middle initial (if any), and last name.

9. **Employee/subscriber name and mailing address:** Enter the Patient Identification Code (PIC). MAA identifies clients by this code, not by their name. This is an alphanumeric code assigned to each MAA client consisting of:

- First and middle initials (*or* a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (or fewer if the name is less than five letters).
- Alpha or numeric character (tiebreaker).

10. **Employee/subscriber dental plan ID number**

14. **Is patient covered by another dental plan?** Circle the appropriate response.

15a. **Name and address of carrier(s):** Enter the name and address of the third-party insurance carrier.

15b. **Group no(s):** Enter the group number(s) of the subscriber to the third-party insurance coverage.

16. **Name and address of other employer(s):** Enter the name and address of the subscriber's employer.

17a. **Employee/Subscriber Name** (if different from patient's): Enter the name of the employee/subscriber.

17b. **Employee/Subscriber Dental Plan I.D. Number**: Enter the dental plan ID # of the employee/subscriber.

17c. **Employee/Subscriber Birthdate**: Enter the birthdate of the employee/subscriber.

18. **Relationship to Patient**: Check the appropriate box.

21. **Name of Billing Dentist or Dental Entity:** Enter the dentist's name or business as recorded with MAA.

Provider Name: Next to the dentist's name, enter the provider number assigned to you by MAA when you signed your Core Provider Agreement. It is the same seven-digit number that appears on the MAA Remittance and Status Report in the ***Provider Number*** area at the top of the page. It is this code by which providers are identified, not by provider name. **Without this number, we may be unable to determine the provider and pay the claim.**

22-23. **Address where payment should be remitted:** Enter the provider's mailing address.

28. **Place of Treatment**: Enter one of the following codes to show the place of service at which the service was performed:

Office	**3**	dental office or ambulatory surgery center
Hosp.	**1**	inpatient hospital
	2	outpatient hospital
	5	hospital emergency room
ECF	**8**	nursing facility
Other	**4**	client's residence
	6	congregate care facility or group home

29. **Radiographs or models enclosed?:** Check the appropriate box. If you check *yes*, indicate how many X-rays are enclosed.

Note:

- Do not send X-rays when billing for services.
- X-rays are necessary only when prior authorization is being requested.
- Please write "X-rays enclosed" on the mailing envelope and mail to the Quality Utilization Section (see Prior Authorization section for address.)

30. **Is treatment result of occupational illness or injury?:** Check the appropriate box. If *yes*, describe the illness or injury and list date(s) of occurrence/onset.

31. **Is treatment a result of auto accident?:** Check appropriate box. If *yes*, please describe and give dates.

32. **Other accident?:** Mark appropriate box. If *yes*, please describe and give dates.

33. **If prosthesis, is this initial placement?:** Enter *yes* or *no*. If *no*, enter reason for replacement and date(s) of extraction(s). If applicable, chart missing teeth for partial(s).

34. **Date of prior placement:** Enter the date of prior prosthesis placement, if known.

36. **Tooth Chart:** If you wish to enter a medical record number, enter it underneath the tooth chart.

37. **Examination and treatment plan:** **Each service performed** must be listed as a separate, complete one-line entry except for x-rays which are allowed multiple units. **Each extraction or restoration** must be listed as a separate line entry.

If billing for removable prosthodontics, missing teeth must be noted on the tooth chart.

Tooth # or Letter: Enter the appropriate tooth number, letter(s):

- 01 through 32 for permanent teeth
- A through T for primary teeth
- SN for supernumerary teeth

Quadrants (Q) or Arches (A) must be identified in the **tooth number column** using one of the following two-digit codes:

UR = Upper Right Quadrant
UL = Upper Left Quadrant
LR = Lower Right Quadrant
LL = Lower Left Quadrant
UA = Upper Arch
LA = Lower Arch

Surface: Enter the appropriate code from the list below to indicate the tooth surface worked on. Up to **four codes** may be listed in this column:

M = Mesial
D = Distal
O = Occlusal
I = Incisal
B = Buccal/Labial
F = Facial
A = ALL (mesial, distal occlusal, buccal and lingual)
L = Lingual

Description of Services: Give a brief written description of the services rendered. When billing for general anesthesia, enter actual beginning and ending times. If you were assisting in surgery, please state "*surgical assist*" here. Next to the description, enter the number of units, if applicable. (***Units*** might mean multiple x-rays using the same procedure code; if two x-rays were taken, enter a 2 in this column. If no number is entered, it is assumed that one unit of service was performed.)

If procedure codes already indicate multiple surfaces (e.g., composite - two surfaces) *do not* indicate multiple units.

If billing for anesthesia, enter *only* the total # of minutes on the claim.

Date Service Performed: Enter the six-digit date of service, indicating month, day, and year (e.g., August 1, 2000 = 080100).

Procedure Number: Enter the procedure code from this fee schedule that represents the procedure or service performed. The use of any other procedure code(s) will result in denial of payment.

Fee: Enter **your usual and customary fee** (not MAA's maximum allowable rate) for each service rendered.

38. Remarks for unusual services: This field is for the nine-digit authorization number assigned for some services by MAA. Enter all nine digits.

This field also may be used for justification for the services rendered, the name of any referring provider or facility, or the name of any provider who administered anesthesia.

Example of Remark: *"Patient fell, broke dentures. Replacement dentures necessary."*

39. Provider Signature: Enter the performing provider's number if it is different from the one shown in *field 21*. If you are a dentist in group practice, please indicate your **unique identification number and/or name**.

40. Address where treatment was performed: Complete this section if the treatment was performed at a different location than indicated in #22 and #23.

41. Total Fee Charged: Total all charges listed.

Payment by other plan: Enter the amount paid by other insurance for these services. Attach the insurance explanation of benefits (EOB) to the claim.

Patient pays: Enter the balance due after insurance.

ADA DENTAL CLAIM FORM

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